

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **ANDRZEJ J. SLASKI, M.D.,**

4 Holder of License No. 6972
5 for the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-12A-6972-MDX

**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER
(License Revocation)**

7
8 On February 6, 2013, this matter came before the Arizona Medical Board ("Board")
9 for consideration of the Administrative Law Judge (ALJ) Brian Brendan Tully's proposed
10 Findings of Fact, Conclusions of Law and Recommended Order. Andrzej J. Slaski, M.D.,
11 ("Respondent") did not appear before the Board; Assistant Attorney General Anne
12 Froedge, represented the State. Christopher Munns with the Solicitor General's Section
13 of the Attorney General's Office was available to provide independent legal advice to the
Board.

14 The Board, having considered the ALJ's decision and the entire record in this
15 matter, hereby issues the following Findings of Fact, Conclusions of Law and Order.

16 **FINDINGS OF FACT**

- 17 1. The Arizona Medical Board ("Board") is the duly constituted authority for the
18 regulation and control of the practice of allopathic medicine in the State of Arizona.
19 2. Andrzej J. Slaski, M.D. ("Respondent"), also known as Andrew Slaski and A.J.
20 Slaski, is the holder of License No. 6972 issued by the Board for the practice of
21 allopathic medicine in the State of Arizona. Respondent's medical license is
22 currently under a complete practice restriction pursuant to a consent agreement.¹
23 3. Respondent's background and training has been as a pediatrician. Approximately
24 three years ago, Respondent began practicing pain management when he worked

25 ¹ Interim Order for Practice Restriction and Consent to the Same dated March 12, 2012.

1 for Dr. David Ruben. Dr. Ruben hired Respondent to write prescriptions for his
2 practice after Dr. Ruben's allopathic license had been placed on probation.
3 Respondent has had no training in pain management.

4 4. In February 2011, Respondent left Dr. Ruben's clinic and opened his own cash-
5 based pain management clinic.

6 5. On October 16, 2012, the Board issued a Complaint and Notice of Hearing
7 charging Respondent with unprofessional conduct in Case Nos. MD-11-0335A and
8 MD-12-0232A. The Complaint and Notice of Hearing was sent to Respondent at
9 his address of record with the Board. The Complaint and Notice of Hearing
10 advised Respondent of the time, date, and location of an evidentiary hearing
11 before the Office of Administrative Hearings. The mailing of the Complaint and
12 Notice of Hearing was returned to the Board as undeliverable to Respondent's
13 address of record.

14 6. The commencement of the scheduled hearing was delayed 15 minutes to allow for
15 the late arrival of Respondent. After the delay, the Administrative Law Judge
16 conducted the hearing in Respondent's absence.

17 **Case No. MD-11-0335A**

18 7. On or about March 16, 2011, the Board initiated Case No. MD-11-0335A after
19 receiving a complaint from a pharmacist regarding Respondent's prescribing
20 practices involving patients PH and CA.

21 8. The complaining pharmacist expressed concern that Respondent was
22 incapacitated and that patients and/or staff may have been taking advantage of
23 him to obtain prescriptions. Respondent appeared at the pharmacy to verify a
24 prescription for patient PH. The pharmacist was concerned about Respondent's
25 behavior at that time. Board staff later determined that Respondent was not
cognitively incapacitated.

9. After the initiation of the Board's investigation in this case, the complaining
pharmacist reported to staff that she had received a prescription from
Respondent's office that did not contain his current practice information.
Respondent later admitted to Board staff that he had used an old prescription pad.

1 10. The Board's assigned medical consultant, Jerome Julian Grove, M.D., is board
2 certified in pain management and anesthesiology. Dr. Grove addressed the
3 allegation of inappropriate prescribing and identified deviations from the standard
4 of care in Respondent's treatment of patients PH and CA.

5 11. Patient PH was a former patient of Dr. Ruben. Patient PH had a history of illicit
6 drug use and had been previously discharged from a pain management practice
7 due to doctor shopping. PH also had a history of reporting stolen medications.

8 12. Patient PH was treated by Respondent at his clinic from approximately February 7,
9 2011, to May 26, 2011.

10 13. Dr. Grove authored a Medical Consultant Report dated August 6, 2011. In his
11 report, Dr. Grove noted the following standard of care in this matter:

12 With respect to chronic pain and patients on chronic opioid therapy,
13 standard of care involves a balanced or comprehensive approach
14 with adjuvant medications and an alternative therapeutic treatment
15 plan in order to potentially minimize known side effects of opioid
16 therapy, including tolerance, physiologic and mental dependency,
17 and to evaluate for diversion, abuse, and addiction. Known risk
18 stratification regarding chronic opioid use for chronic pain patients
19 recommends a higher level of screening for patients who have had a
20 history of illicit drug abuse and for those patients under 35 years of
21 age.²

22 14. At the hearing, Dr. Grove credibly testified consistent with the findings in his
23 Medical Consultant Report.

24 15. Dr. Grove opined that Respondent's inappropriate prescribing to PH deviated from
25 the standard of care. Dr. Grove based his opinion on the following factors: (i) PH
had a history of illicit drug abuse; (ii) PH had been discharged from a previous pain
management practice due to doctor shopping; (iii) PH had reported stolen
prescription medication when at least a portion of the medication should have
been taken; (iv) Respondent prescribed high levels and quantities of short acting
medication to PH, being #300 Oxycodone 30 mg tablets per month, without any

² Exhibit 17 at 1-2.

1 implemented tools to address addiction, diversion, and abuse; and (v) Respondent
2 did not require PH to undergo urine drug testing while Respondent treated the
3 patient.

4 16. Patient CA is also a former patient of Dr. Ruben. She was originally seen for
5 treatment on March 29, 2010. CA had been "diagnosed with degenerative disc
6 disease in the cervical spine as well as mild disk bulge in the lumbar spine
secondary to a work related injury" ³

7 17. In January, February, and March of 2011, Respondent treated CA, who had also
8 become Respondent's secretary at his new clinic. The evidence of record
indicates that CA returned to Dr. Ruben's clinic for treatment on April 14, 2011.

9 18. In addition to the standard of care described above, Dr. Grove also opined that
10 "[i]n reference to the treatment and prescribing of controlled narcotics to someone
11 who is currently and directly employed by the prescriber, I believe the standard of
12 care also dictates that the patient should seek another physician, as many conflict
of interest issues arise." ⁴

13 19. The evidence of record established that Respondent deviated from the standard of
14 care in his treatment of CA. Dr. Grove observed that Respondent continued to
15 prescribe high levels of short acting pain medication to CA, who was known to
16 have failed previous drug tests. Dr. Grove also noted that Respondent failed to
17 document any office notes for the period of treatment when CA was employed by
18 Respondent. Dr. Grove opined that CA, a high-risk patient, should have had her
19 pain re-evaluated, non-narcotic options readdressed, or the possibility of abuse
looked into to a higher degree.

20 20. Potential harm in the case of patient PH involved Respondent providing access to
21 highly abused pain medications to a patient who had a high risk for returning to
addiction and/or potential for diversion and abuse.

22 21. Respondent's treatment of patient CA exposed the chronic pain patient to the
23 potential for harm because she had very easy access to high levels of potentially
24

25 ³ Exhibit 17 at 3.

⁴ Exhibit 17 at 4.

addictive pain medications without Respondent addressing her history of red flags relating to addiction, abuse, and diversion.

22. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warning provided to the patient, and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). The evidence of record established that Respondent's records for patients PH and CA were inadequate because they were often illegible and incomplete. At the hearing, Dr. Grove gave the following assessment: "The actual documentation for each of the patients was minimal, to put it bluntly, and/or illegible, and there was some other concerning issues where loss of medicines and other, quote/unquote, aberrant behavior for these opioid medications were not addressed at all."⁵ In addition, Respondent did not dictate or write any office notes for the period of treatment when CA was employed by Respondent.

Case No. MD-12-0232A

23. The Board initiated Case No. MD-12-02332A after receiving a complaint from the mother of patient PS on February 29, 2012, alleging inappropriate prescribing of narcotics to her twenty-five year old son. The mother is a registered nurse.

24. The Board assigned the investigation of Case No. MD-12-0232A to Celina Shepherd.

25. On March 8, 2012, Ms. Shepherd, along with the board's medical consultant Jennifer J. Sosnowski, M.D., F.A.A.F.P., interviewed Respondent regarding this matter. After the interview, Dr. Sosnowski issued an Interview Summary dated March 8, 2012. During the interview, Respondent admitted that he met PS at a Starbucks on one occasion after PS complained that his medications had been stolen. Respondent wrote PS a prescription for the allegedly stolen medications

⁵ HT at 33, ll. 17-22.

- 1 during that meeting. Respondent acknowledged that he had not performed a
2 physical examination of PS at that meeting. Respondent further admitted to
3 meeting patients, including PS, outside of his office.
- 4 26. This case was also assigned to Richard J. Ruskin, M.D., an outside medical
5 consultant. Dr. Ruskin specializes in interventional pain management of both
6 chronic and acute pain. Dr. Ruskin is board certified in anesthesiology, internal
7 medicine, and interventional pain management.
- 8 27. The evidence of record established that Respondent treated PS with high-dose
9 narcotics for pain, although his MRI showed only minimal degenerative disc
10 disease. Respondent admitted that he was never able to confirm the patient's
11 primary complaint of fibromyalgia.
- 12 28. There is no indication in PS's chart that Respondent performed a full examination
13 of the patient's painful sites.
- 14 29. There was one urine drug screen in PS's medical record and it was positive for
15 illicit drugs but negative for alprazolam, the medication that Respondent had
16 prescribed. There is no indication that Respondent addressed this issue with PS
17 but he continued to prescribe the alprazolam and oxycodone.
- 18 30. Included in PS's medical chart were several Arizona Board of Pharmacy
19 ("CSPMP") restricted medication lists that revealed that PS had been obtaining
20 narcotics from at least seven providers including Respondent. There is no
21 indication in the medical chart that this issue had been addressed by Respondent.
- 22 31. In addition to reviewing the medical records for patient PS, Dr. Ruskin also
23 reviewed five randomly selected patient charts from Respondent's practice. The
24 charts reviewed were for patients JA, DH, KV, JR, and JP. Respondent
25 prescribed high-dose oxycodone to all five patients, either alone or in combination
with a benzodiazepine.
32. Dr. Ruskin authored "A Medical Consultant Report and Summary" dated May 29,
2012, wherein he addressed each of the patients' medical records. At the hearing,
Dr. Ruskin credibly testified consistent with the findings in the report. In his report,
Dr. Ruskin identified the following standards of care applicable to those patients:

- The initial evaluation of a chronic pain patient shall include a pain history, a directed physical examination, review of diagnostic studies, previous interventions, drug history and assessment of coexisting diseases or conditions.
- Treatment plan should be tailored to the individual. The treatment objective should be clearly stated. The use of high-dose opioids carries substantial risk: habituation, potential for misuse and diversion, deterioration of mental and physical functioning and overdose. Therefore, consideration should be given to different treatment modalities including rehabilitation behavioral strategies noninvasive techniques and the use of non-opioid medications. An opioid trial should not be initiated in absence of a complete assessment of the chronic pain patient.
- Informed consent should be obtained including a discussion between the physician and the patient with regard to the risks and benefits of the use of controlled substances.
- There should be a periodic review of the treatment efficacy and reassessment of the etiology of the patient's pain, as well as the patient's state of health, their functional status, adequacy of analgesia, opioid side effects, quality of life and indications of medication misuse.
- Attention should be given to the possibility of a decrease in functioning, or quality of life, because of opioid usage.
- The physician should consider consulting a pain specialist or psychologist depending on the expertise of the practitioner and the complexity of the presenting problem.
- The medical record should be accurate, legible and provide sufficient information for another practitioner to assume continuity of the patient's care. These records should contain documentation in the areas listed in the bullet points above.⁶

33. Dr. Ruskin opined that Respondent fell below the above-described standards of care in his treatment of PS. The bases of his opinion are as follows: (i) Respondent's medical records for PS contain no evidence that Respondent ever performed a physical examination of the patient; (ii) Respondent did not make a legitimate attempt to determine the etiology of the patient's pain; (iii) Informed consent was not obtained from the patient; (iv) If PS did have fibromyalgia, treatment with high-dose opioids and benzodiazepines was not appropriate; and

⁶ Exhibit 43.

- (v) Respondent did not consider other treatment modalities other than high-dose opioids.
34. Dr. Ruskin identified that PS suffered the following actual harm from Respondent's treatment: (i) Respondent enabled and perpetuated an addictive drug disorder in the patient, and (ii) Respondent's treatment negatively impacted the patient's health, social well-being, and quality of life.
35. Dr. Ruskin identified the potential harm resulting from Respondent's treatment of PS as follows: (i) Respondent put PS at risk of drug-overdose, and (ii) Respondent put the general public at risk because PS was likely diverting drugs to other individuals.
36. Dr. Ruskin found Respondent's habit of repeatedly meeting PS in non-clinical locations to exchange controlled substance prescriptions for cash as "highly inappropriate and unprofessional." Dr. Ruskin described Respondent's failure to recognize and act upon PS's use of illicit drugs and misuse of prescribed medications as "egregious."
37. Dr. Ruskin opined that Respondent deviated from the standards of care in his treatment of patients JA, DH, KV, JR, and JP.
38. Respondent's records for patients JA, DH, KV, JR, and JP were inadequate because Respondent failed to document a complete history and physical examination, the nature and etiology of pain, and a comprehensive plan of care for each patient.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over Respondent and the subject matter in these two cases.
2. Pursuant to A.R.S. § 41-1092.07(G)(2), the Board has the burden of proof in this matter. Pursuant to A.R.S. § 32-1451.04, the standard of proof is by clear and convincing evidence. The evidence of record supports the conclusion that the Board met its burden of proof in this matter by uncontroverted clear and convincing evidence.

- 1 3. The Board complied with the requirements of A.R.S. § 32-1451(R) by sending a
2 copy of the Complaint and Notice of Hearing to Respondent by certified mail to
3 Respondent's last known address of record with the Board.
- 4 4. The evidence of record established that Respondent committed unprofessional
5 conduct in violation of A.R.S. § 32-1401(27)(a), specifically, A.R.S. § 32-
6 1491(A)(1)(a), when failed to list his current address and telephone number when
7 he wrote prescriptions to PH.
- 8 5. The evidence of record established that Respondent committed unprofessional
9 conduct in violation of A.R.S. § 32-1401(27)(e) by his failure to maintain adequate
10 medical records for patients PH, CA, PS, JA, DH, KV, JR, and JP.
- 11 6. The evidence of record established that Respondent committed unprofessional
12 conduct in violation of A.R.S. § 32-1401(27)(q) because his treatment of the patients
13 discussed in this matter resulted in potential and/or actual harm to the patients and
14 the public. The documentary and testimonial evidence presented at the hearing
15 support this conclusion.

16 **RECOMMENDED ORDER**

17 It is recommended that Respondent's License No. 6972 for the practice of allopathic
18 medicine in the State of Arizona be revoked on the effective date of the Order entered in
19 Case Nos. MD-11-0335A and MD-12-0232A.

20 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

21 Respondent is hereby notified that he has the right to petition for a rehearing or
22 review. The petition for rehearing or review must be filed with the Board's Executive
23 Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The
24 petition for rehearing or review must set forth legally sufficient reasons for granting a
25 rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days
after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not
filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to
Respondent.

1 Respondent is further notified that the filing of a motion for rehearing or review is
2 required to preserve any rights of appeal to the Superior Court.

3 DATED this 17th day of February, 2013.

4 THE ARIZONA MEDICAL BOARD

5
6 By 
7 LISA WYNN
8 Executive Director

9 ORIGINAL of the foregoing filed this
10 17th day of February, 2013 with:

11 Arizona Medical Board
12 9545 East Doubletree Ranch Road
13 Scottsdale, Arizona 85258

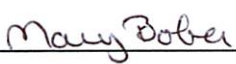
14 COPY OF THE FOREGOING FILED
15 this 17th day of February, 2013 with:

16 Cliff J. Vanell, Director
17 Office of Administrative Hearings
18 1400 W. Washington, Ste 101
19 Phoenix, AZ 85007

20 Executed copy of the foregoing
21 mailed by U.S. Mail this
22 17th day of ~~June~~ Feb, 201~~2~~ 3 to:

23 Andrzej J. Slaski, M.D.
24 Address of Record

25 Anne Froedge
Assistant Attorney General
Office of the Attorney General
CIV/LES
1275 W. Washington
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